

# REGISTRATION FORM

PHYSICIAN NAME		OFFICE NAME/LOCATION	
Patient First Name		Middle Name	Last name
			SSN
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Aliases	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other
Permanent Address		Home Phone Number	Check preferred contact number <input type="checkbox"/>
City		Work Phone Number	<input type="checkbox"/>
State	Zip	Mobile Phone Number	<input type="checkbox"/>
Emergency Contact Name	Relationship to Patient	Emergency Contact Home Phone	Check preferred contact number <input type="checkbox"/>
Address		Work Phone Number	<input type="checkbox"/>
City	State	Zip	Mobile Phone Number <input type="checkbox"/>
Responsible Party <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other		Guarantor First Name	Middle Name
		Last name	
Guarantor Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Guarantor Date of Birth	Guarantor Home Phone Number	Guarantor SSN
Guarantor Employer Address		Guarantor Employment Status	Guarantor Work Phone Number
City	State	Zip	Guarantor Employer Name
Primary Insurance Name		Date Effective From	Primary Insurance Address
Patient Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Insurance Phone Number	Subscriber/Insurance ID Number	Group Number
Name of Subscriber		Date of Birth	Employer Name
Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Active Military Duty <input type="checkbox"/> Student – Full Time <input type="checkbox"/> Student – Part Time <input type="checkbox"/> Other			
Covered through: <input type="checkbox"/> Employment <input type="checkbox"/> Retirement <input type="checkbox"/> COBRA <input type="checkbox"/> Other		Employer Size <input type="checkbox"/> 1-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100+	Copay Amount
Secondary Insurance Name		Date Effective From	Secondary Insurance Address
Patient Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Insurance Phone Number	Subscriber/Insurance ID Number	Group Number
Name of Subscriber		Date of Birth	Employer Name
Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Active Military Duty <input type="checkbox"/> Student – Full Time <input type="checkbox"/> Student – Part Time <input type="checkbox"/> Other			
Covered through: <input type="checkbox"/> Employment <input type="checkbox"/> Retirement <input type="checkbox"/> COBRA <input type="checkbox"/> Other		Employer Size <input type="checkbox"/> 1-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100+	Copay Amount
Is this related to a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did this injury occur at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>I authorize the physician/physician group above to provide treatment and or tests to me. In signing this agreement, I certify that the above stated facts are correct. I/We hereby assign and authorize payment of all insurance benefits directly to the physician/physician group above. I/We hereby authorize the physician/physician group above to furnish information from the patient's medical records to insurers, compensation carriers, healthcare facilities, or other agencies which may be providing financial assistance for the patient's care. I understand that I am financially responsible for any balance not covered by insurance.</p>			
_____ / _____ / _____ Date		X _____ Signature of Insured or Authorized Person	